

HEALTH INSURANCE PREMIUM PAYMENT UNIT POLICYHOLDER INFORMATION

IN ORDER TO RECEIVE YOUR NEXT HEALTH INSURANCE PREMIUM PAYMENT, YOU MUST ATTACH A COPY OR ORIGINAL OF YOUR MOST RECENT PAYCHECK STUB SHOWING HEALTH INSURANCE DEDUCTION. YOU MUST COMPLY WITHIN TWO WEEKS TO RECEIVE YOUR NEXT MONTH'S PREMIUM PAYMENT (USE THE ENCLOSED ADDRESSED, STAMPED ENVELOPE). FAILURE TO DO SO WILL RESULT IN NON-PAYMENT OF PREMIUM.

CHANGE INFORMATION:(complete the following **ONLY** if there is a change in information)

Employee	SSN#	Insurance Plan
Your Name		Employer
Employer Phone #	Employer Address	

Please mark appropriate boxes:

<input type="checkbox"/>	change in employment status (full-time/part-time)
<input type="checkbox"/>	loss of employment
<input type="checkbox"/>	change in employer
<input type="checkbox"/>	change in TPL (insurance carrier)
<input type="checkbox"/>	change in amount of premium
<input type="checkbox"/>	cancellation of policy
<input type="checkbox"/>	change in members covered under group policy (employee only/family plan)
<input type="checkbox"/>	serious medical condition
<input type="checkbox"/>	case transferred to another locality
<input type="checkbox"/>	other

Please describe:

The Department of Medical Assistance Services pays insurance premiums on behalf of eligible individuals. Failure to report changes may result in overpayments, retractions, underpayments, cancellation of coverage, or incorrect processing of medical claims. If you are aware of any information which would affect these payments, mail this form to:

Virginia Department of Medical Assistance Services

600 East Broad Street

Richmond, VA 23219

Phone: (804) 786-0912 (Local only) (800) 432-5924 (Long Distance)

FAX: 804-786-5799